United States General Accounting Office

GAO

Report to Congressional Committees

September 2003

MEDICARE

Modifying Payments for Certain Pathology Services Is Warranted

GAO-03-1056

September 2003

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Highlights

Highlights of GAO-03-1056, a report to congressional committees

MEDICARE

Modifying Payments for Certain Pathology Services Is Warranted

Why GAO Did This Study

In 1999, the Health Care Financing Administration, now called the Centers for Medicare & Medicaid Services (CMS), proposed terminating an exception to a payment rule that had permitted laboratories to receive direct payment from Medicare when providing technical pathology services that had been outsourced by certain hospitals. The Congress enacted provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to delay the termination. The BIPA provisions directed GAO to report on the number of outsourcing hospitals and their service volumes and the effect of the termination of direct laboratory payments on hospitals and laboratories, as well as on access to technical pathology services by Medicare beneficiaries. GAO analyzed Medicare inpatient and outpatient hospital and laboratory claims data from 2001 to develop its estimates.

What GAO Recommends

GAO suggests that the Congress may wish to consider not reinstating the provision that allows laboratories to receive direct payment from Medicare for technical pathology services provided to hospital patients. GAO recommends that the Administrator of CMS terminate the policy of allowing laboratories to receive direct payment. CMS stated it would carefully consider our recommendation.

www.gao.gov/cgi-bin/getrpt?GAO-03-1056.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119.

What GAO Found

In 2001, approximately 95 percent of all Medicare prospective payment system (PPS) hospitals—hospitals that are paid predetermined fixed amounts for services—and critical access hospitals (CAH), which receive reimbursement from Medicare based on their reasonable costs, outsourced some technical pathology services to laboratories that received direct payment for those services. However, the median number of outsourced services per hospital was small—81.

If laboratories had not received direct payments for services for hospital patients, GAO estimates that Medicare spending would have been $42 million less in 2001, and beneficiary cost sharing obligations for inpatient and outpatient services would have been reduced by $2 million. Most hospitals are unlikely to experience a financial burden from paying laboratories to provide technical pathology services. If payment to the laboratory is made at the current rate, a PPS hospital outsourcing the median number of technical pathology services outsourced by PPS hospitals, 94, would incur an additional annual cost of approximately $2,900. There would be no financial impact for the 31 percent of rural hospitals that are CAHs, as they would receive Medicare reimbursement for their additional costs.

Medicare beneficiaries' access to pathology services would likely be unaffected if direct laboratory payments are terminated. Hospital officials stated they were unlikely to limit surgical services, including those requiring pathology services, because limiting these services would result in a loss of revenue and could restrict access to services for their communities.

Payments to Laboratories by Medicare and Medicare Beneficiaries for Technical Pathology Services Provided to Hospital Inpatient and Outpatients, 2001

	Dollars in millions		
	Services provided to inpatients	Services provided to outpatients	Total
Estimated Medicare payments	$18	$33	**$51**
Estimated beneficiary copayments	5	8	**$13**
Total	**$23**	**$41**	**$63**[a]

Source: CMS.

Note: GAO analysis of 2001 inpatient and outpatient claims and Medicare physician fee schedule payment and copayment rates.

[a]Total does not add due to rounding.

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Abbreviations

AHA	American Hospital Association
APC	ambulatory payment classification
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAH	critical access hospital
CAP	College of American Pathologists
CMS	Centers for Medicare & Medicaid Services
DRG	diagnosis-related group
HCFA	Health Care Financing Administration
MPFS	Medicare physician fee schedule
NRHA	National Rural Health Association
POS	Provider of Services
PPS	prospective payment system
SNF	skilled nursing facility

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United States General Accounting Office
Washington, DC 20548

September 30, 2003

Congressional Committees

Hospitals receive fixed, predetermined amounts under Medicare's hospital inpatient and outpatient prospective payment systems (PPS) for providing necessary services to Medicare beneficiaries. By paying hospitals fixed amounts under a PPS, Medicare seeks to encourage them to operate efficiently, as hospitals retain the difference if their payments exceed their costs of providing necessary services. Hospitals that outsource services for their patients generally pay suppliers of those services directly, and the suppliers do not receive payment from Medicare.

In 2000, the Congress enacted provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[1] to delay for 2 years application of a rule issued by the Health Care Financing Administration (HCFA),[2] the agency responsible for administering Medicare. The rule terminated an exception to the inpatient and outpatient PPS that permitted one type of supplier—laboratories—to receive payment directly from Medicare when providing technical pathology services[3] to beneficiaries who are hospital patients. The BIPA provisions applied only to "covered hospitals," those hospitals that had agreements with laboratories in effect as of July 22, 1999, the date HCFA proposed the rule, under which the hospitals outsourced technical pathology services to laboratories, and the laboratories received payment from Medicare for these services. Under these agreements, some hospitals may outsource all of their technical pathology services to laboratories, while others may outsource only some of their services, such as complex procedures that are rarely performed or overflow services at times of full capacity.

[1]BIPA, Pub. L. No. 106-554, app. F, § 542, 114 Stat. 2763, 2763A-550.

[2]In July 2001, the agency's name was changed from HCFA to the Centers for Medicare & Medicaid Services. In this report, we refer to the agency as HCFA when discussing actions it took under that name.

[3]Technical pathology services involve the preparation of tissue samples removed during surgery for examination by a pathologist. Such services are performed by a laboratory technician, known as a histotechnician, and involve cutting, mounting, and staining the specimen on a microscope slide. Under Medicare, these services are referred to as the "technical component" of a pathologist's service. Medicare covers as a separate service the pathologist's examination of a specimen, which is called the "professional component."

Numerous issues were raised when HCFA issued its rule in 1999 to terminate direct Medicare payment to laboratories for technical pathology services. At the time, HCFA stated that Medicare was paying twice for those services provided to hospital inpatients, once to the hospital through the inpatient PPS payment and once to the laboratory through a separate payment.[4] In addition, outsourcing hospitals had an advantage because they did not pay the cost of technical pathology services outsourced to laboratories, while other hospitals had to pay for the cost of these services from their inpatient PPS payments.[5] Furthermore, application of Medicare cost-sharing rules resulted in added costs to inpatient beneficiaries admitted to outsourcing hospitals, compared to those for inpatients at other hospitals. Some hospitals and laboratories and their affiliated pathologists voiced concern, however, that termination of the laboratories' direct payments would increase hospitals' costs, decrease laboratories' revenues, and cause hospitals to stop performing surgical services, particularly in rural areas, reducing beneficiaries' access to services.

Although the BIPA provisions expired at the end of 2002, the Centers for Medicare & Medicaid Services (CMS) made an administrative decision to continue directly paying laboratories for technical pathology services provided to hospital patients.[6] In recent bills, both the House of Representatives and the Senate have included language to further delay application of the CMS rule.

In BIPA, the Congress directed that we report on how terminating direct laboratory payments would affect hospitals, laboratories, and access to technical pathology services by Medicare beneficiaries.[7] As agreed with the committees of jurisdiction, we (1) describe the number and type of hospitals outsourcing technical pathology services and their service volumes, (2) estimate how termination of direct laboratory payments would affect Medicare expenditures, beneficiary cost-sharing obligations, and hospital costs, and (3) examine how terminating direct laboratory

[4]HCFA's 1999 rule pertained to services delivered only to hospital inpatients because the outpatient PPS was not yet implemented. The outpatient PPS was implemented in August 2000; therefore, when the BIPA provisions were enacted in December of that year, they applied to both inpatient and outpatient services.

[5]Other hospitals either perform technical pathology services themselves or outsource and directly pay laboratories for such services.

[6]CMS Program Memorandum, Transmittal B-03-001 (Jan. 17, 2003).

[7]BIPA § 542(d), 114 Stat. 2763A-551.

payments would affect beneficiaries' access to technical pathology services in hospitals.

We used Medicare claims and provider data to identify Medicare beneficiaries receiving technical pathology laboratory services concurrently with hospital services. Using 2001 data, the most recently available, we estimated the number of urban and rural PPS hospitals and critical access hospitals (CAH),[8] which are paid their reasonable costs rather than PPS payments,[9] outsourcing technical pathology services. We also estimated the volume of and payments for these services. We relied on these data because there is no list of covered hospitals and the laboratories to which they outsource technical pathology services.

We interviewed officials at CMS, the Department of Health and Human Services Office of Inspector General, and the Congressional Budget Office, as well as representatives from several Medicare carriers.[10] In addition, we interviewed representatives from national associations representing hospitals and pathologists and representatives from 13 laboratories and 17 urban and rural PPS hospitals in eight states and an additional 2 laboratories in another state. We visited a laboratory and a rural hospital that outsources technical pathology services. We also spoke with officials from two CAHs. Our methodology is detailed in appendix I. We did our work from June 2002 through September 2003 in accordance with generally accepted government auditing standards.

[8]CAHs were created as part of a program developed to maintain access to hospital services in rural areas. In general, to be designated as a CAH, a hospital must (1) be in a rural area more than a 35-mile drive from another hospital (or certified as a necessary provider in the area), (2) make available 24-hour emergency care services, (3) have no more than 25 beds (of which no more than 15 may at any time be used for acute care to provide average acute care stays of no more than 96 hours per patient), (4) meet most Medicare requirements generally applicable to hospitals, and (5) have a quality assessment and performance improvement program, as well as procedures for utilization review. 42 U.S.C. § 1395i-4(c)(2) (2000).

[9]Reasonable cost reimbursement is based on the actual cost of providing services, including direct and indirect costs of providers, and excludes any costs that are unnecessary in the efficient delivery of services.

[10]Medicare carriers are the contractors responsible for processing claims and paying laboratories, physicians, and certain other providers.

Results in Brief

We estimate that in 2001, 4,773 PPS hospitals and CAHs, representing 95 percent of all such facilities, outsourced at least some technical pathology services to laboratories that received direct payment from Medicare for those services. In 2001, out of approximately 1.4 million outsourced technical pathology services, the median number of outsourced services per hospital was 81. Urban hospitals outsourced almost twice as many services as rural hospitals. In addition, 64 percent of these services were for outpatient beneficiaries.

If laboratories had not received direct payment for services for hospital patients, we estimate that Medicare spending would have been $42 million less in 2001, with $18 million and $24 million in savings for inpatient and outpatient services, respectively, and overall beneficiary cost sharing would have been reduced by $2 million. Comparatively, in 2001, payments to laboratories providing technical pathology services to beneficiaries who were hospital patients equaled over $63 million, including Medicare payments of about $51 million and beneficiary cost sharing of almost $13 million. Most hospitals are unlikely to experience a large financial burden from paying laboratories to provide technical pathology services. However, the extent to which an individual hospital's costs and a laboratory's revenues would change if direct laboratory payments are terminated would depend on the rates negotiated by that hospital and laboratory. If payment to the laboratory is made at the current rate, a PPS hospital outsourcing the median number of technical pathology services outsourced by PPS hospitals, 94, would incur an additional annual cost of approximately $2,900. Also, there would be no financial impact from terminating direct laboratory payments for the 31 percent of rural hospitals that are CAHs because they would be reimbursed for their costs of outsourcing technical pathology services.

Medicare beneficiaries' access to pathology services would likely be unaffected if direct payment to laboratories is terminated, as hospital representatives we spoke with stated that, because of financial and community access concerns, their hospitals were unlikely to limit surgical services, including those requiring pathology services. In addition, almost all hospital representatives we spoke with said their hospitals would likely continue to outsource technical pathology services as it would generally be less costly than performing the services themselves.

We suggest that the Congress may wish to consider not reinstating the provisions that allow laboratories to receive direct payment from Medicare for providing technical pathology services to hospital patients. We recommend that CMS terminate its policy of permitting laboratories to

receive payment from Medicare for these services. In commenting on a draft of this report, CMS stated that it is important that payment policy encourage efficiencies in the provision of technical pathology services and that it would carefully consider our recommendation. National associations that received a draft of the report for comment disagreed that direct laboratory payments should be terminated, as they believe such a change would have negative effects on beneficiaries' access to services and on rural hospitals. However, hospital representatives we spoke with said their hospitals would likely continue to outsource technical pathology services. In addition, we do not believe paying laboratories directly for these services will place a significant financial burden on rural hospitals as we estimated that the median number of technical pathology services outsourced by rural hospitals in 2001 was only 61.

Background

Medicare payment policies for technical pathology services have changed over the years as new payment systems for hospital and physician services have been implemented and modified. Beginning with the implementation of the hospital inpatient PPS on October 1, 1983, through the implementation of the Medicare physician fee schedule (MPFS) on January 1, 1992, and the outpatient PPS on August 1, 2000, payment for technical pathology services changed as fixed, predetermined payment replaced reasonable cost or charge-based reimbursement for Medicare services.

Implementation of the Inpatient PPS

Under the inpatient PPS, each inpatient stay is classifed into a diagnosis-related group (DRG) based primarily on the patient's condition. Each DRG has a payment weight assigned to it that reflects the relative cost of inpatient treatment for a patient in that group compared with that for the average Medicare inpatient. Included in the costs of each DRG are nonphysician services provided to inpatients by the hospital and its outside suppliers. A hospital receives a DRG payment from Medicare and a deductible amount from a beneficiary for each inpatient benefit period.[11] Each year, the DRG weights are recalibrated to account for changes in resource use, and the payment rate is adjusted by an update factor to account for changes in market conditions, practice patterns, and

[11]A benefit period starts with an inpatient hospital or skilled nursing facility (SNF) admission and ends after 60 consecutive days of no inpatient care. 42 C.F.R. § 409.60(a) and (b) (2002). For 2003, the deductible for each hospital inpatient benefit period is $840.

technology. Medicare separately pays physicians, including pathologists, and certain other professionals for the direct services they provide to inpatients.

When developing the inpatient PPS in the early 1980s, HCFA determined that technical pathology services outsourced to laboratories were an integral part of the professional services provided by the laboratories' pathologists, not separate nonphysician services. Based on that determination, the payment for technical pathology services provided by laboratories was included in the larger payment to the laboratories and not included in the PPS payments.[12]

Implementation of the MPFS

In 1992, HCFA implemented the MPFS, which created distinct payments for the professional and technical components of most diagnostic services, including pathology services. Although the MPFS included a distinct payment to laboratories for technical pathology services, HCFA did not revise its policy to prohibit laboratories from continuing to receive the separate Medicare payment for outsourced technical pathology services provided to inpatients. Under the MPFS, beneficiaries are responsible for a copayment equal to 20 percent of the payment for physician services, including technical pathology services. Thus, inpatient beneficiaries whose technical pathology services were outsourced by a hospital to a laboratory that received direct payment from Medicare were responsible for a copayment, while other inpatients were not.

Termination of MPFS Payments to Laboratories for Technical Pathology Services

On July 22, 1999, HCFA proposed ending Medicare payments under the MPFS to laboratories for technical pathology services provided to hospital inpatients on or after January 1, 2000.[13] Under the proposal, laboratories, like suppliers of other nonphysician services, would have to seek payment from hospitals for technical pathology services provided to hospital inpatients.

[12]In this report, we use the term "laboratory" to include bo.5238 0 Td(e the)0inclf06 0 3nonphysici0 0 '

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